

ORIGINAL RESEARCH

Doctors' identity transitions: Choosing to occupy a state of 'betwixt and between'

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Abstract

Context: During transitions, doctors engage in identity work to adapt to changes in multiple domains. Accompanied by this are dynamic 'liminal' phases. Definitions of liminality denote a state of being 'betwixt and between' identities. From a social constructionist perspective, being betwixt and between professional identities may either involve a sense of disrupted self, requiring identity work to move through and out of being betwixt and between (ie, temporary liminality), or refer to the experiences of temporary workers (eg, locum doctors) or those in dual roles (eg, clinician-managers) who find themselves perpetually betwixt and between professional identities (ie, perpetual liminality) and use identity work to make themselves contextually relevant. In the health care literature, liminality is conceptualised as a linear process, but this does not align with current notions of transitions that are depicted as multiple, complex and non-linear.

Methods: We undertook a longitudinal narrative inquiry study using audio-diaries to explore how doctors experience liminality during trainee-to-trained transitions. In three phases, we: (a) interviewed 20 doctors about his or her trainee-to-trained transitions; (b) collected longitudinal audio-diaries from 17 doctors for 6-9 months, and (c) undertook exit interviews with these 17 doctors. Data were analysed thematically, both cross-sectionally and longitudinally, using identity work theory as an analytical lens.

Results: All participants experienced liminality. Our analysis enabled us to identify temporary and perpetual liminal experiences. Furthermore, fine-grained analysis of participants' identity talk enabled us to identify points in participants' journeys at which he or she rejected identity grants associated with his or her trained status and instead preferred to remain in and thus occupy liminality (ie, neither trainee nor trained doctor).

Conclusions: This paper is the first to explore longitudinally doctors' liminal experiences through trainee-to-trained transitions. Our findings also make conceptual contributions to the health care literature, as well as the wider interdisciplinary liminality literature, by adding further layers to conceptualisations and introducing the notion of occupying liminality.

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1 | INTRODUCTION

Health care professionals experience numerous transitions during his or her career.¹⁻³ From a social constructionist viewpoint, transitions can be defined as ongoing processes of psychological, social and educational adaptations over time necessitated by changes in context, interpersonal relationships and identities.⁴ By conceptualising doctors' experiences of transitions as multiple, complex and ongoing, we can regard these experiences as times for intensive learning, but also as periods of increased stress and burnout.⁴⁻¹⁰ Previous transitions research suggests that priority be given to personalised approaches to doctors' transitions, with increased opportunities for formal and informal learning about new roles.⁸ This is seen as fundamental to doctors' well-being, to his or her organisation and ultimately to patients as doctors navigate transition experiences.⁸ Whereas previous research has centred on the support for, and challenges of, doctors' transition experiences,⁵⁻¹⁰ this study extends this research by focusing on higher-stage trainees' professional identity transitions and how such trainees experience liminality in order to better enhance understandings of, and provisions for, doctors in transition.

To offer immediate clarification, from a social constructionist perspective, we conceptualise professional identities as dynamic, and as formed and reformed through dialogue and interaction (also known as identity work; see below).¹¹ Liminality, in the traditional anthropological sense, is defined as describing the condition of being betwixt and between two positions (eg, as not a girl but not yet a woman) in a context in which a ritualised occurrence facilitates the shift from an old to a new status, such as in female puberty rites of passage.^{12,13} Thus, within the context of higher-stage trainees' transitions, liminality may be experienced during the transition from trainee to trained doctor (such as when a doctor becomes a consultant), alongside changing expectations of doctors that support these liminal experiences. We conceptualise liminality in a more complex manner than this anthropological definition, however, and we articulate this in detail below.

1.1 | Identity work

First, we articulate what we mean by 'identity work.' Identity work can be considered an orienting process experienced by people through which people become members of particular social groups such as professional ones.¹⁴ During times of workplace transition, identity work comes to the fore as individuals and his or her significant others such as family members (personal), and old and new colleagues (professional), grapple with complex and dynamic changes in multiple domains (eg, social, cultural, psychological and physical).^{4,8}

From a social constructionist perspective, identities are drawn together through personal experiences, others and organisations in numerous ways, including through language, symbols, sets of meanings and values.¹⁵ Identity work refers to '... people being engaged in forming, repairing, maintaining, strengthening and revising their identities.'¹⁶ Thus, identity work endeavours to develop, portray and support new identities, and can be conceptualised as a reflexive narrative in which

meaning is derived from interaction between contending dialogues and a range of experiences.¹⁷ Individuals will project certain identities (ie, claim identities), as others simultaneously support (ie, grant) those projected identities as authentic (or not) and may also bestow on individuals certain identities that may be either claimed or rejected.¹⁷⁻²⁰ As vital elements in identity construction processes, these identity claims and grants can stem from self and other talk, plus non-verbal communication.^{21,22} Such identity construction, whether it is co-constructed or contested by others, becomes part of an individual's self-narrative.^{20,23} The outcomes of identity work are, therefore, negotiated by the 'strength and pliability of contextual discourses' and through individual interpretations of identities granted.²⁰ Furthermore, conceptualisations of identity work as a transient, linear process in which individuals strive towards a secure sense of self can be challenged.²⁴ Indeed, situations such as job insecurity or career transitions may actually catalyse identity work, whereby people expend efforts to 'create, confirm and disrupt a sense of self.'²⁴

1.2 | Identities and liminality

Exploring the wider literature, we find that career transitions can often be delineated by a dynamic liminal phase, in which the sense of 'who I am' gives way to a sense of 'who I'm becoming.'²⁵ Moving away from traditional, linear notions of liminality, current conceptualisations suggest that identity shifts are less ritualised and aggregation to new identities can often be partial.²⁶ For example, a study from the management literature articulates the shift from aspiring paratrooper to paratrooper, in which recognition of the new identity happens during quiet contemplation rather than through a public passing out ceremony.²⁷ Similarly, in the United Kingdom (UK) doctors' transitions out of training involve the ceremonial process of receiving a certificate of completion of training (CCT) and inclusion on the specialist register. However, our research suggests that doctors experience this transition as ongoing and complex such that his or her personal recognition of his or her new specialist doctor identity takes time beyond the simple receiving of a CCT.⁸

This state of in-betweenness is seen as bounded in space and time and linked to uncertainty.²⁶⁻³⁰ Thus, liminality is often portrayed as something that 'significantly disrupts one's internal sense of self and place in a social system.'²⁶⁻³⁰ Researchers argue that such disruptions can bring individuals to need to resolve his or her liminal status through intense identity work.³⁰ Indeed, individuals develop identities in ways that are important to themselves and others in order to move across these liminal spaces.^{23,26} Beech argues that people experiencing significant periods of liminality also position themselves chronologically by referring to the past, present and future.²⁶ Through engagement in self-reflection and projecting a future-self, these liminars can be seen as simultaneously looking forwards and backwards in order to move out of the liminal space. Liminality, conceptualised in this way, is thought to be 'temporary.'^{26,31,32}

Ybema et al,²³ however, have described more complex and social understandings of liminality by introducing the notion of perpetual

liminality. Perpetual liminality is a state in which individuals undertake identity work to make themselves contextually, socially and temporally relevant.²³ This perpetual liminality is most evident in workers experiencing enduring in-betweenness, such as impermanent workers (eg, locum doctors) and dual-role professionals (eg, clinician-managers).³²⁻³⁴ Whereas temporary liminality creates a feeling of 'not-X-anymore-but-not-yet-Y,' perpetual liminality creates an ongoing sense of 'being neither-X-nor-Y' or 'being both-X-and-Y.'²³ As with temporary liminality, perpetual liminality is often imposed by others, with individuals becoming so-called boundary bricoleurs, who use identity work to 'cast and re-cast themselves to different audiences at different times.'^{23,35} In a manner that differs from more linear understandings of temporary liminality, perpetual liminals rely less on temporal reflections of their old and new selves.²³ Instead, they respond to immediate competing demands and loyalties by continuously switching identities, thus experiencing lasting unpredictability and growing accustomed to inhabiting a social 'no-man's land,' which they employ as an 'operating base to build allegiances.'²³ The literature suggests that this long-lasting sense of liminality can lead to negative emotional consequences as a result of ongoing feelings of uncertainty and in-betweenness.^{29,35}

Although the interdisciplinary literature shows more complex understandings of liminality, much previous work has focused on groups that operate at the margins of organisations, such as temporary workers or those brought in to undertake short-term tasks (eg, management consultants).^{21,26,35} As such, there is a lack of literature on individuals already embedded within organisational structures (such as medical training) but going through job changes (such as trainee-to-trained doctor transitions).

1.3 | Liminality and health care education

A keyword search (using the term 'liminal*') of top medical education journals reveals that considerable research exists around threshold concepts in undergraduate learning with reference to how learners are confronted with troublesome knowledge that challenges his or her developing professional identities.^{36,37} The notion of knowledge as threshold is likened to a portal through which learners must travel when experiencing a lack of authenticity, often imitating behaviours considered appropriate, and described as a liminal phase.³⁸ The focus for learners is on moving through these thresholds and on to transformational learning, which changes the ways learners perceive concepts and the world around them.³⁷ This sphere of health care education research often centres on obtaining a definitive list of threshold concepts (eg, caring or responsibility).³⁹⁻⁴² Relevant here, however, is the unquestioned notion in this literature that learners will progress from troublesome knowledge through a liminal phase to transformational learning (so, temporary liminality).³⁶ For example, Browne et al used a linear conceptualisation of the transition from medical professional to educator to describe the temporary liminal phase between the two identities as stressful.⁴³ Others have focused on physical spaces as liminal, such as the hospital corridor as a liminal space for discussion, knowledge exchange and informal

learning, or how a new medical school building becomes a liminal space between the profession and the university.^{44,45}

In summary, much of the current health care education liminality literature focuses on undergraduate rather than postgraduate learners such as trainee doctors, conceptualises transitions and associated liminality experiences as more linear and temporary than current theoretical thinking suggests, gives insufficient attention to how identity work contributes to liminality experiences and how these liminal experiences might change over time, and assumes that liminality experiences are always stressful.³⁹⁻⁴²

1.4 | Study aims and research questions

Using identity work as a lens for our analysis, this novel study explores how doctors experience liminality during the trainee-trained transition. Our research questions are:

1. What liminal experiences (and associated identity work) do doctors narrate as he or she moves through trainee-trained transitions?
2. How do liminal experiences (and associated identity work) change over time during trainee-trained transitions?

2 | METHODS

2.1 | Study design

This paper comes from a wider longitudinal narrative study exploring trainee-trained doctors' transitions.⁸ Longitudinal narrative inquiry allowed us to explore the unique experiences of each participant over time.⁴⁶ Longitudinal audio-diaries (LADs) are particularly applicable as sense-making tools during times of change because they foreground storytelling and, used alongside entrance and exit interviews, help participants to explore his or her experiences in depth longitudinally.^{46,47}

Our all-female research team included experienced social constructionist researchers. Two of us (LG and CER) are experienced health care education researchers, and one (DJ-S) is an experienced educational transitions researcher. One of us (LG) has a clinical background and two of us (CER and DJ-S) have psychology backgrounds. We have all (LG, CER and DJ-S) published transitions research, including research into doctors' transitions.^{4,8,48,49}

2.2 | Sampling and recruitment

Following university graduation, UK doctors typically begin postgraduate training with 2 years of Foundation training before moving to specialty training, which can take anything between 3 and 8 years (depending on the specialty). Following the successful completion of specialty college assessments, the trainee achieves a CCT and is placed on the specialty register. We purposely sampled UK trainee

doctors expected to secure CCTs within the following 6 months to allow us to longitudinally explore doctors trainee-trained experiences. For the purposes of this paper, we describe these doctors throughout as 'trained doctors' as this is a generic term accounting for multiple possible destinations following completion of training (eg, consultant, general practitioner [GP], clinical fellow).

Following ethics and appropriate institutional approvals, potential participants were invited by email through local educational leads. A total of 20 trainees agreed to participate in a three-phase study involving: (a) an entrance interview; (b) a 6-9-month LAD phase, and (c) an exit interview.

2.3 | Data collection

At entrance interview, participants were asked about his or her understanding of transitions and what he or she expected from his or her upcoming transitions. Participants also reflected on his

or her training experiences to date and discussed what influenced his or her readiness for trainee-trained transitions. Participants were then invited to participate in the LAD phase. During this phase, participants were asked to record stories, thoughts and reflections pertaining to trainee-trained transition experiences over 6-9 months. Participants used smartphones to make recordings and emailed them to the lead author (LG); three participants chose to submit written diaries. Finally, second-phase participants were invited to take part in exit interviews in which he or she were asked whether he or she conceptualised transitions in the same way, how his or her personal and professional identities had developed, what had influenced his or her experiences (either positively or negatively) and, when exploring the diary transcripts, what he or she had learned from his or her experiences. Of the 20 participants who completed entrance interviews, 17 completed the two remaining study phases. All audio data (ie, interview and LAD recordings) were confidentially transcribed using an experienced transcription company. Table 1 depicts the data collected across

TABLE 1 Summary of data collected

| Name ^a | Gender | Specialty | Post-training role | Diaries, n | Study duration, months | Amount of data, min ^c | Amount of data, words |
|--------------------|-----------|--|---|------------|------------------------|----------------------------------|-----------------------|
| Petra | F | Medicine | Management and clinical fellow | 1A + 1W | 8 | 106 | 18 576 |
| George | M | Medicine | Consultant | 10A | 10 | 88 | 15 400 |
| Andrew | M | Medicine | Consultant | 0 | N/A | 37 | 6592 |
| Jack | M | Medicine | Consultant | 21A | 8 | 120 | 16 517 |
| Arun | M | Medicine | Consultant | 30A | 8 | 217 | 30 732 |
| Anna | F | Medicine | Consultant | 21A | 8 | 213 | 38 651 |
| Craig | M | Medicine | Consultant | 0 | N/A | 27 | 4127 |
| Vicky | F | Medicine | Consultant | 8A | 7.5 | 95 | 16 508 |
| Megan | F | Medicine | Consultant | 13A | 9 | 193 | 37 362 |
| Amy | F | Medicine | Consultant | 9A | 9 | 162 | 22 965 |
| Liz | F | Medicine | Consultant | 10A | 7.5 | 126 | 16 705 |
| Karen ^b | F | Surgery | Locum consultant | 15A | 9 | 156 | 27 917 |
| Lucy | F | Surgery | Clinical fellow | 13A | 10 | 125 | 21 663 |
| Steven | M | Surgery | Clinical fellow | 11A | 10 | 134 | 18 863 |
| Doug | M | Surgery | Consultant | 0 | N/A | 48 | 7873 |
| Julie | F | General Practice | GP retainer | 9A | 8 | 131 | 23 809 |
| Jason | M | General Practice | Locum GP | 8A | 8 | 151 | 21 513 |
| Freddie | M | General Practice | Academic GP | 25A | 9 | 194 | 26 026 |
| Morag | F | Anaesthetics | Consultant | 4A + 4W | 8 | 121 | 25 431 |
| Heather | F | Laboratory-based | Consultant | 1A + 8W | 8 | 102 | 22 724 |
| Totals | 11 F; 9 M | 11 medicine; 4 surgical; 3 general practice; 1 anaesthesia; 1 laboratory-based | 14 hospital consultants; 2 dual role; 2 clinical fellows; 2 GPs (various) | 242 | Average 8.6 months | 2669 | 419 954 |

Abbreviations: A, audio; F, female; GP, general practitioner; M, male; N/A, not applicable; W, written.

^aAll pseudonyms.

^bKaren is used as a case study in this paper.

^cEntrance interview + longitudinal audio-diary + exit interview (where relevant) combined.

the three phases, as well as demographic information for each participant.

Given that we had a tight study aim, a specific sample (all UK higher-stage trainees 6 months prior to CCT), drew on established theories (eg, identity work), had strong dialogue between participants and the researcher through longitudinal engagement, and a thematic analysis strategy combining both cross-sectional and longitudinal qualitative analyses, we believe that our longitudinal sample of 17 higher-stage trainees possessed sufficient information power to address our study aims.⁵⁰

2.4 | Data analysis

We first used framework analysis to inductively identify broad themes in our dataset.⁵¹ This thematic analysis involved several stages: (a) members of the wider research team (see Acknowledgements) familiarised themselves with the data through repeated explorations of transcripts and audiorecordings; (b) a thematic framework was developed by having each research team member separately analyse a subset of data and propose key themes and then allowing the team to negotiate higher-order themes for the coding framework together, and (c) these higher-order themes were utilised to code all data using ATLAS.ti Version 7.0 (ATLAS.ti, Scientific Software Development GmbH, Berlin, Germany). The overarching themes focused more broadly on the multiple experiences of doctors' trainee-trained transitions, identifying facilitators and inhibitors to transitions.⁸ As a novel addition to this general data analysis (and thus not already reported), the authors of this current paper (LG, CER and DJ-S) then undertook an in-depth analysis of the data coded to just one of these higher-order themes, entitled 'professional identity.' This theme focused on participants' specific talk and descriptions of experiences related to his or her identity work. As discussed above, we drew on identity work theory,¹⁴ plus current conceptualisations of temporary and perpetual liminality,^{23,31,32} in order to provide an in-depth cross-sectional and longitudinal analysis of our data to answer our two research questions.

3 | RESULTS

All participants completing the three study stages experienced liminality related to his or her identity as he or she moved from trainee to trained doctor. Consistent with previous literature, our data analysis enabled us to identify temporary and perpetual liminality in participants' experiences. However, fine-grained analysis of participants' identity talk also enabled us to identify novel liminal experiences: points in some participants' journeys at which he or she actively rejected identity grants from others associated with his or her trained doctor status. Instead, participants undertook identity work that either maintained his or her liminal

positions (as neither trainee nor trained doctor) or that actively maintained a trainee identity; we describe this novel type of liminality as occupying liminality.

In the following sections, to address research Question 1, we first describe multiple participants' different experiences of liminality and his or her associated identity work, illustrating all three types of liminality (temporary, perpetual and occupying). Then, to address research Question 2, we illustrate the multiple liminal experiences of one selected participant over time. Indeed, we chose the story presented by Karen (a pseudonym) because, as was typical of many participant experiences, we were able to identify multiple forms of liminality and associated identity work across her journey. Furthermore, using her longitudinal story allowed us to explore more fully why some participants choose to occupy liminality.

3.1 | Doctors narrating temporary liminality

Most doctors narrated temporary liminal identities at some point across his or her transitions; this was particularly pertinent for doctors who had already secured trained posts but were waiting to start them. At this point, these participants had completed the paperwork for the CCT and were looking forward to the new roles but were also reflecting backward on the experiences. For example, Andrew used identity work to project his confidence in doing his first on-call shift as a consultant (Table 2, Quote 1). Looking backwards, he recognised that his previous experiences of acting up as a consultant (with others granting him a consultant identity) had prepared him well. Some doctors in this temporary liminal phase described how his or her formal CCT paperwork was complete, but that he or she were yet to start his or her formal roles (this time lag between the completion of paperwork and the taking up of a substantive 'trained' post is common in the UK), as illustrated by Steven's and Arun's experiences (Table 2, Quotes 2 and 3). In each of these experiences, focused on clinical practice, both doctors claimed his or her trained doctor identities but were still waiting for others' grants of these identities. Other doctors described the importance of rituals (eg, celebrations with colleagues) in helping them claim his or her new consultant identities through this liminal period. This was especially important to signify doctors moving into senior roles in contexts in which he or she remained at the site of his or her training, as discussed by George (Table 2, Quote 4). Whereas some described the experiences of temporary liminality positively (eg, Andrew, Steven, Arun and George [Table 2, Quotes 1-4]), others experienced frustration as he or she perceived that grants of trained doctor identities were withheld by others. For example, although Heather claimed a consultant identity for herself by explaining that she was functioning as a consultant, she also described that she was still a trainee and reported that others withheld consultant identity grants to her by excluding her from important decision-making meetings (Table 2, Quote 5).

| Quote | Pseudonym | Data excerpts |
|-------|-----------|---|
| 1 | Andrew | <i>'I think having sort of done that acting up period and actually done it quite well and people sort of commented: "[we] thought you really were a consultant at this stage [despite being a trainee]." I think that's given me a lot of confidence' (Entrance interview)</i> |
| 2 | Steven | <i>'I saw the relevant patients and then discussed the cases. This made me feel valued and comfortable that my knowledge was sufficient to interact productively at this level ... although I am not acting with the consultant's responsibilities, I'm in the unusual position of being ... called a consultant in paperwork terms [but] still within a training post' (LAD 2)</i> |
| 3 | Arun | <i>'... an opportunity to have a bit more of senior clinical decision making ... a chance to kind of spread my wings a bit and have a bit more of the senior role in the department and I was supported by the consultants recognising ... where I am in my training and what the next stages are ... at the end of this week ... there's going to be the closing date of application for ... consultant jobs. I am going to be applying for one of them' (LAD 6)</i> |
| 4 | George | <i>'This was my final night shift as a trainee ... enjoy some food with the nursing staff that marks the end of one phase before the distinct transition to the next phase. It's also important if you're staying within the same place to mark an endpoint so that on return this will ease the transition into the next role' (LAD 9)</i> |
| 5 | Heather | <i>'I am in an awkward position of nominally being a trainee but functioning as a consultant. As a trainee, I am not invited to attend the consultant meetings where decisions are made ... Unfortunately, these are not fed back to me after a conclusion has been reached' (Written diary 1)</i> |

TABLE 2 Examples of temporary liminality

| Quote | Pseudonym | Data excerpts |
|-------|-----------|--|
| 1 | Petra | <i>'... this is a different type of maintaining trust when you are not an inhabitant of that sphere ... and then they [clinicians] think that every problem they have, the one to blame for is management. And you sit in management meetings and they're saying, "Oh, doctors don't engage, doctors don't care, doctors don't understand." So, you've got the same-you sit in both worlds ...' (Exit interview)</i> |
| 2 | Freddie | <i>'I've been going in for the practice meetings ... just because I want to be part of the team and also keeping up to date with what is happening in the practice ... I think they appreciate that as it is not really essentially part of my contract ...' (LAD 6)</i> |
| 3 | Freddie | <i>'... I'm not sure I feel ... well I'm working as an academic, certainly I still feel like I'm only on the first rung of the ladder ... I don't feel like I can say that I am an academic in that sense ... I think I would prefer to say that I am developing a strand or aspect of my career in academia ...' (Exit interview)</i> |

TABLE 3 Examples of perpetual liminality

3.2 | Doctors narrating perpetual liminality

Some doctors narrated perpetual liminality, often through the possession of dual roles. For example, Petra, who had a clinical manager role, discussed how others saw her in the different environments (Table 3, Quote 1). Note that although this role is unusual in the UK for a newly trained doctor, it is not unusual in non-nationalised systems of health care for doctors to have management responsibilities immediately

post-training. First, Petra talked about how, in her managerial role, she used intensive identity work as a clinician to build relationships with other clinicians given that she was not a fixed member of that team or workplace. Second, she described how, when sitting in management meetings, others saw her as a manager, forgetting that she was also a clinician as the others complained about clinicians. Petra, however, saw herself as someone who was both a clinician and a manager and used this experience of both worlds to try and broker the different

TABLE 4 Examples of occupying liminality

| Quote | Pseudonym | Data excerpts |
|-------|-----------|--|
| 1 | Julie | '... that'll be a reasonable way of describing it [the role of a GP retainer] "treading water", just now ... I turn up ... I work my hours, I do what I'm asked to do. I'm quite happy to do it ... [they] take on a huge amount of responsibility by being a partner ... I'm not really ready for that [due to children still being very young<] ...' (Exit interview) |
| 2 | Lucy | '... this year [as a clinical fellow] for me was ... whether actually personally I was up for the job ... testing ground because it is a very stressful job, there is a lot of responsibility, and I was not sure whether I will actually be up for it ... or whether it is going to make me happy ...' (Exit interview) |
| 3 | Jason | 'It's been 2 weeks since I started working as a self-employed locum GP. I've enjoyed very much working on my own terms and being able to decide how much I wish to work ... as a GP trainee, I think it's quite silly that we only work in one practice for the whole 3 years and, therefore, only see one system ...' (LAD 3) |
| 4 | Morag | 'I still feel it odd when I introduce myself as a consultant anaesthetist, and I usually qualify it by saying, "But I've only been a consultant for 6 months" [laughs], "so don't expect too much"' (Exit interview) |
| 5 | Megan | 'I did some reflecting over the holiday period on life as a consultant so far ... I suppose what has made me think ... I still feel a bit like a glorified trainee ... need a bit more time to get properly into the job' (LAD 11) |
| 6 | Anna | 'I became a consultant and ... all the juniors I had worked with ... started to treat me slightly differently ... I went to meet one of the registrars I've worked with for 3 years... she said, "Oh, it is just quite scary that you are now my senior." And I said to her ... "I don't want to be treated any different just because I now have the title consultant"' (Exit interview) |
| 7 | Amy | '... a lot of what feels like a transition experience is quite personal with regards to my consultant colleague. I am struggling, I suppose, to find my place with my consultant who used to be my supervisor ... it would be nice to have a supervisor to be able to go to ... I don't feel that I can go to my consultant colleague because it feels like I would be putting her in a position of being supervisor rather than colleague and ... it's a supervisor that I want ... I am just struggling with the idea' (LAD 1) |

group views. Another participant, Freddie, a GP clinical academic, experienced perpetual liminality in a different way to Petra. Affiliated for 1 day per week as a qualified GP to a family medicine practice, Freddie undertook identity work to try to establish himself as part of the clinical team, such as by going to meetings outside his working hours (Table 3, Quote 2). Alongside this, he questioned his identity as a clinical academic until the very end of his time in the study, 8 months into his clinical academic role. Indeed, his identity struggles mirrored his feelings of being neither a full-time member of the clinical practice nor a full member of the academic community (Table 3, Quote 3).

3.3 | Doctors narrating occupying liminality

One way by which we identified some participants as narrating occupying liminality was through his or her career choices as participants actively positioned themselves as perpetual liminars. The

reasons for these choices included a desire to wait until he or she felt more ready for trained doctor responsibilities and a wish to work flexibly. For example, Julie described herself as 'treading water' as a retained GP (a GP funded by the local training body to work part-time until he or she wants a more permanent position), and as choosing to be in a liminal role as she did not want the responsibility of being a GP partner as her children were very young and she worked part-time (Table 4, Quote 1). Similarly, Lucy, a surgeon, chose to be a clinical fellow for a year in order to decide whether she wanted to stay in her specialty (Table 4, Quote 2). Another GP, Jason, chose to work as a locum to maintain work flexibility and to experience different occupational environments (Table 4, Quote 3). Interestingly, across our longitudinal dataset, we were able to identify numerous occurrences within and across participants in which he or she rejected claims and/or grants of his or her trained identities. For example, both Morag and Megan used identity work to reject grants of the consultant identities;

TABLE 5 Karen's longitudinal experiences

| Quote | Month on study | Data excerpts |
|-------|--|---|
| 1 | Month 1: pre-certificate of completion of training | <i>'My husband [says] "Are you sure you don't want to go into something more compatible with family life ... you could have been a GP and had a little minor ops [operative] list ... you would have been happy" but I know I wouldn't have been happy ... absolutely delighted that I'm at the end of my training and hopefully it will all work out ...'</i> (Initial interview) |
| 2 | Month 2: during grace period | <i>'I've been trying to be proactive and stepping up ... doing lists on my own ... doing as much as possible to impress people here ... trying to keep my head down ... work as hard as possible'</i> (LAD 5) |
| 3 | Month 2: during grace period | <i>'I turned down the locum job [in a different hospital<] ...'</i> (LAD 6) |
| 4 | Month 3: during grace period | <i>'... we are going into [names month] this week and my grace period ends technically at the end of [names month in 3 months' time]'</i> (LAD 6) |
| 5 | Month 5: during grace period | <i>'... sorting out the department's annual [event<]... I really do not have time for, but again I want to be seen to be playing every role possible ... be seen to be a team player, make things happen'</i> (LAD 8) |
| 6 | Month 6: during grace period | <i>'I had a frank discussion with my clinical lead ... told me that they would approach management ... it would be fine [having a job secured<] ... it's an odd situation ... [the work going on to confirm a consultant position is] all a bit hush hush, a bit cloak and dagger'</i> (LAD 10) |
| 7 | Month 7: during grace period | <i>'I only have a contract for the next five-and-a-half weeks but they keep assuring me that it will all be fine and that there have been some positive emails going around, although I am not privy to these emails ... still basically feel like I am in limbo, hanging in the balance'</i> (LAD 11) |
| 8 | Month 8: offered locum job | <i>'[I] have some good news, I have just literally today had a letter confirming my appointment as a locum consultant in the hospital of my choice ... I am extremely relieved as my ... contract ended yesterday ... I've finally got something on paper, which says I have a consultant job ... the whole process has been difficult and stressful and very full of uncertainty'</i> (LAD 13) |
| 9 | Month 9: working as locum consultant | <i>'I was at home and I got a call out... in my mind it sounded awful ... on the way in I am thinking, "I can do this, I have done this plenty of times, if necessary I can phone a friend" ... but I was really, really hoping it wasn't as bad as they made out on the phone ... then I was talking to one of my more established colleagues the next day and he was saying, "No, you should be coming in thinking, hoping it is that, so you can make a difference and change something." I think it will be a long time before I am at that stage ...'</i> (Exit interview) |
| 10 | Month 9: working as locum consultant | <i>'It's more difficult with the more senior trainees ... they were kind of pushing me to let them do things ... whereas it is obvious to me to say to them, "Look ... I've only just been appointed ... I need to do this case myself and it needs to go well, not just for the [patient] but for me to gain my confidence and I'm not interested in doing assessment for anybody [trainees]"'</i> (Exit interview) |
| 11 | Month 9: working as locum consultant | Interviewer: <i>'Do you see yourself as the boss?'</i> Karen: <i>'Sometimes ... yesterday in theatre ... with a very difficult case and my colleague who I am taking over from, he had to do most of it ... I was very glad he was there, I didn't really feel like the boss yesterday... I feel a bit like a registrar knocking on his door and saying "My plan is this, do you agree?" ... and then you think "This is not very consultant-like behaviour, to seek help with that"'</i> (Exit interview) |

her participation with an exit interview (Figure 1). Karen moved through the formal CCT process in Month 2 of her time in the study but held her trainee post for a further 6 months (in what was termed by her employers as a formal 'grace period': a 6-month period during which doctors continue to work at his or her training hospital and applying for consultant posts) before being offered a locum consultant position in her training hospital during Month 8. In her initial interview, Karen described how, as a woman in her male-dominated subspecialty, she felt that she had to prove

herself more to make herself competitive in the local job sector. This was particularly pertinent given that she was the mother of two small children and married to another doctor (who had already completed his training) and therefore could not move her family to another geographical location. Although Karen's training had been extended as a result of two periods of maternity leave and part-time working, she talked in her entrance interview about how driven she was to work in her highly competitive subspecialty, and how pleased she was to be moving to trained status, despite her

husband questioning her subspecialty's suitability for her family life (Table 5, Quote 1).

3.4.1 | Karen's temporary liminality: No longer a trainee but not a consultant either

In Karen's second month in the study, she moved through the formal ritual of receiving her CCT, which she described as 'a slight anticlimax' (LAD 4) and into her grace period at her training hospital (Figure 1). Through this grace period, Karen was liminal; she was no longer a trainee, but she was not yet a consultant. During this liminal phase (time-bound and thus temporary), Karen described her identity work to project her future consultant self through emphasising herself as competent and collegiate (Table 5, Quotes 2 and 3). As Karen moved through this grace period, the tone of her LADs shifted to emphasise her uncertainty as a liminar (and its associated stresses). Karen presented herself as trapped in her grace period and as having complete reliance on others (of higher status) to offer her work as a consultant. During this, Karen remarked in every diary on how long it was until the end of her grace period (Table 5, Quote 4). Additionally, Karen's identity work accelerated; for example, she volunteered to lead an annual staff event (despite having limited time) because she saw this as an opportunity to show herself to be a team player and a leader who gets things done (Table 5, Quote 5). Furthermore, Karen reported in her diaries numerous conversations about the possibility of securing a consultant position in her training setting.

In terms of her identity work in her audio-diaries, we can see Karen's claims as 'consultant doctor' within that unit, which were being acknowledged by other stakeholders important in the decision-making process (Table 5, Quote 6). Karen struggled with what she described as the uncertain 'cloak and dagger' nature of others' attempts to find her a job. Having only partial access to information, she relied on others to share information, and was arguably denied important leadership identity grants from senior consultants (Table 5, Quote 7). Finally, and much to Karen's relief, the day after her grace period ended she was offered a job as a locum consultant, covering for another consultant who was going on sabbatical. This meant that there was an overlap between Karen's starting of her new consultant job and the leaving of the individual she was replacing. In her diary entry, although elated by this news, Karen reflected back on how stressful the grace period had been (Table 5, Quote 8).

3.4.2 | Karen occupies liminality: Being a consultant but not yet becoming a consultant

After starting her new consultant role, Karen did not submit an audio-diary for a month. In her next diary, she reflected on her first experiences as a consultant on call. Karen's identity work shifted in emphasis from working to demonstrate that she was competent, a team player and a leader (as discussed previously) to someone who

'felt a bit of a fraud being called the consultant' and rejected others' grants of her new consultant identity (LAD 15, Month 9). Indeed, she contrasted her hopes for simple cases when on call with her colleague's beliefs that she should be hoping for complicated cases so that she could make a difference. We therefore see her rejecting others' granting of her consultant identity, stating that she requires time to claim this identity for herself (Table 5, Quote 9).

Karen also talked about her relationships with senior trainees within the workplace and the senior trainees expectations that she would step into the educator role inherent in being a consultant. In her exit interview, Karen simultaneously claimed a learner-trainee identity and rejected others' grants of her now educator-consultant identity, describing herself as in competition with her senior trainees for difficult theatre cases in order to develop her own surgical confidence and expertise (Table 5, Quote 10).

Finally, the overlap between herself and the colleague she was replacing seemed to affect how Karen felt about her position within the workplace. As well as occupying liminality here, she was also a perpetual liminar as a result of her locum status. Karen expressed relief in the support this overlap provided. Although this overlap meant that she still felt 'a bit like a registrar,' she felt she should not be behaving like a registrar, thus indicating her anxieties about her self-imposed occupation of liminality (Table 5, Quote 11).

4 | DISCUSSION

We explored liminal experiences narrated by doctors across trainee-trained transitions. Answering our first research question, we found that participants experienced liminality in three ways. First, most experienced temporary liminality at some point. Through identity work, participants engaged in self-reflection and considered past, present and future selves in order to expedite shifts towards this or her new identity, often relying on 'consultant' identity grants from others to move them out of liminality.²⁶ Second, our findings suggest that some doctors experienced perpetual liminality, undergoing enduring in-betweenness through dual roles.²³ Participants were seen to use identity work to make themselves contextually and socially relevant, becoming boundary bricoleurs responding to competing loyalties and demands by continuously switching identities (eg, from clinician to academic).^{23,32-35} Third, and novel to theoretical notions of liminality, individuals would sometimes purposely occupy liminality through its active creation and maintenance. For example, doctors would engage in identity work to reject grants of his or her new trained doctor identities in order to purposely occupy the liminal space between trainee and trained doctor. We suggest that, in a manner contrary to the external imposition of temporary and perpetual liminality, individuals can and do actively choose to be liminars, thereby exerting agency and control over his or her own liminality.

In terms of our second research question, our analysis revealed that a conceptualisation of liminality as a linear progression from one professional identity (eg, trainee doctor) to another (eg, trained doctor) is overly simplistic. Indeed, through our temporal analysis of individuals' experiences across the longitudinal dataset, we noted that participants

did not always proceed in a linear manner through the liminal phase. As Karen's experiences illustrate, context, relationships (both interpersonal and organisational) and systems also influenced the professional identities claimed by, and granted to, our participants, which often fluctuated from one diary to the next, and thus did not always progress directly towards a trained doctor identity.

When we consider why people might choose to occupy liminality, we need to return to how transitions are conceptualised. Jindal-Snape considers transitions as multiple and multidimensional (multiple and multidimensional transitions theory), with transitions in one context of an individual's life (eg, a new job) triggering transitions in other contexts (eg, a home move).⁴ Research on doctors' career transitions aligns with this conceptual thinking, identifying such transitional phases as complex and often non-linear.⁵⁻¹⁰ Hoyer and Steyaert suggest that during career changes, individuals sometimes have conflicting desires for coherence and ambiguity, which can be punctuated by feelings of anxiety and loss, with individuals developing defensive responses to such feelings.²⁸ We suggest, therefore, that liminal spaces can come to represent places in which individuals can dwell to respond to these feelings. Indeed, liminal spaces can become safe spaces for individuals' reflection and planning as he or she experience the complexity of significant multiple transitions. To illustrate this point using our longitudinal case, Karen used her liminal space to reflect on her early experiences of being a consultant and getting used to this new consultant identity. Therefore, we argue that occupying of liminal spaces, as our data illustrate, allowed our participants time to make sense of his or her developing identities.

4.1 | Contribution to the literature on transitions and liminality

This research extends previous work on doctors' transitions, which has narrowly focused on the challenges of, and support for, transition experiences, and leads to more advanced understandings of trainee-trained transitions.⁵⁻¹⁰ Our research also offers more fulsome understandings of the identity work involved in transitions as doctors move through his or her career, highlighting both the complexity of those experiences and the associated identity work (eg, claiming and granting). Furthermore, exploration specifically of liminality and identity work over time extends the current health care education literature on liminality, which has so far tended to focus on broader notions of threshold concepts.³⁶⁻³⁸ Whereas previous health care literature and the wider interdisciplinary literature have focused mostly on notions of temporary liminality,³⁶⁻⁴⁵ our study findings extend these, illustrating doctors' narrations of *perpetual* liminality and occupying liminality, and offering a more complex and multidimensional picture of transitions than has been presented previously. Indeed, the longitudinal nature of our analysis allowed us to show patterns of liminal experiences over time, which challenges some previous health care education research in which liminality is presented as a troublesome linear phenomenon that resolves with time.^{36,37} Indeed, by contrast with this, our research suggests that experiencing liminality is not troublesome for some,

but is instead a necessary experience and an opportunity for reflection. Finally, our work extends understandings of liminal experiences to later stages of doctors' careers and thus beyond previous research focusing on medical students.³⁹⁻⁴³

To summarise, this study is the first of its kind to explore longitudinally the liminal experiences of doctors during trainee-trained transitions. Furthermore, our findings make a novel contribution to the wider literature on liminality^{23,35} by adding this notion of occupying liminality, whereby individuals actively maintain liminal identities as safe spaces in which to reflect and make sense of new experiences.

4.2 | Methodological strengths and limitations

Our study has various methodological strengths. First, our qualitative data have sufficient information power because we collected voluminous longitudinal data (interviews and diaries) from a relatively large and diverse sample (eg, in terms of gender and specialty), which increases the potential transferability of the findings to other UK doctors.⁵⁰ Second, the longitudinal nature of this study also allowed us to explore participants' unique experiences over time.^{46,47} Indeed, the diaries became a central mechanism through which participants were able to secure a safe space for reflection (and possibly a liminal space in itself), in which he or she could share (and revisit) his or her thoughts and feelings pertaining to his or her transitions.⁸ Third, the data collected within the diaries were current thoughts and feelings, and therefore were not filtered by memory as these so often are in interviews, particularly those conducted long after events have taken place.^{46,47} Fourth, the inclusion of exit interviews allowed us to return to the diaries with participants, enabling them to clarify and expand on his or her experience over time.⁴⁶ Finally, our team-based approach to data analysis encouraged rigour and reflexivity.⁵² Indeed, although all of the researchers (LG, CER and DJ-S) are female, our diverse backgrounds (eg, clinical, psychology, education, etc.) meant that we brought diversity to the analysis, leading to a more multifaceted interpretation of the data.⁵³

However, our study is not without its limitations and these should be considered before drawing conclusions. First, most doctors were hospital-based clinicians, meaning that our study findings may not be as transferable to non-hospital doctors. Second, our participants were very much at the beginning of their the journey as senior clinicians and hence our findings do not represent later stages of trainee-trained transitions. Third, although we noticed some patterns in our data by participant characteristics (eg, participants experiencing perpetual liminality typically had dual roles, those reporting identity grants as trained doctors were often male, those occupying liminality were mostly female, etc.), this interpretation should be treated with caution in view of the small size of our sample. Finally, our findings have been interpreted through the theoretical lenses we chose (namely, identity work theory, multiple and multidimensional transitions theory and

liminality theory), which have privileged the interpersonal rather than structural factors influencing liminality; we acknowledge that our findings may have been different had we chosen alternative theories.^{54,55}

4.3 | Implications for education practice

Our findings emphasise a need to recognise that doctors will experience liminality in complex and often non-linear ways during significant career transitions. Our findings suggest therefore that priority be given to personalised approaches to supporting individuals in transitions.⁸ Indeed, case studies from our data could be used for teaching purposes to help explain the different facets of liminality to learners and educators in order to facilitate open discussion about transition experiences. Increased preparation for and acceptance of the liminality doctors will experience and may actively occupy during his or her career journey should thus be developed amongst trainees and trainers alike and used as an opportunity to reflect on and articulate any concerns before and when trainees are liminals. This could be achieved through, for example, supportive conversations with mentors, peers and more experienced colleagues. Additionally, better awareness of perpetual liminal experiences (such as when undertaking dual or temporary roles) should facilitate mentorship discussions around how to manage such perpetuity and the responsibilities that come with multiple roles. The possibility of occupying liminality to adapt to multiple transitions should also be emphasised. Indeed, occupying liminality, as a response to high-stakes transitions across medical careers, is something that organisations and systems should recognise and support. A more planned and supportive approach should allow doctors to make positive use of liminal experiences and simultaneously navigate any challenges.

4.4 | Implications for further research

As a new concept, further study exploring and confirming the notion of occupying liminality is recommended. Furthermore, more specific exploration of perpetual liminality, including the experiences of health care professionals in dual roles (such as clinician-managers), and how this is experienced long-term should also be considered. Additionally, given our focus on (early) trainee-trained medical career transitions, we would encourage further longitudinal study of liminality to explore the transferability of our study findings both temporally (eg, later stages of trainee-trained doctor transitions) and spatially (eg, medical or other health care professional-educator transitions). Finally, we would recommend an exploration of how liminality interacts with personal identities (eg, gender, age, ethnicity, etc.) in order to obtain a clearer picture of who may be more likely to occupy liminality and in what circumstances.

CONFLICTS OF INTEREST

None.

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AUTHOR CONTRIBUTIONS

LG undertook all data collection, contributed to data analysis, wrote the first draft of this paper, and redrafted multiple iterations. CER and DJ-S contributed to the data analysis and edited multiple iterations of the paper. All authors (LG, CER and DJ-S) contributed to the conception and design of the study, secured funding, and approved the final manuscript prior to submission.

ETHICAL APPROVAL

This study was approved by the University of Dundee Human Research Ethics Committee.

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